Center for Molecular Cancer Diagnostics, INC.

Cytology: Urine

Methodology Name And Description:	Microscopy
Specimen Requirements:	Testing Volume/Size: 10-20 mL (prefer 20-50 mL) Type: Urine; Fixed in PreserveCYT Container: Clean, leakproof container; Transport Temperature: Ambient (Prefer Refrigerated)
Minimum Specimen Requirement	Volume/Size: 1 - 2 mL;
Special Info:	Collect at least 30 to 60mL fresh urine in clean container, mix with 30 ml of PreserveCYT from CYTEC. Transport fixed urine to laboratory. Label container with the patient's name, clinic number, date and specimen submitted. REQUIRED BY FEDERAL LAW: Specimen must be accompanied by Cytology requisition giving patient's name, age, clinic number, clinician, clinical history, procedure location, specimen submitted, time and date. FISH for bladder cancer can be requested from the same specimen.
Clinical Info:	Evaluation for atypical cells suspicious or diagnostic of malignancy
Days Performed:	Monday – Friday (CMCD Holidays Excluded)
Reported:	1 -2 Days from receipt of acceptable specimen in lab
Reference Range	Cytology, Urine - Normal
CPT Code(s):	88112(x1)

CLIA# 36D2061372
CAP# 7541618
ADDRESS: 8285 Darrow Road, Ste 101 Twinsburg, OH 44087
PHONE: 330-405-2623

Center for Molecular Cancer Diagnostics, INC.

LAB USE ONLY

Received by:

Date Rec'd: | Time Rec'd:

ACCOUNT INFORMATION

Account No. | **Phone No.**

Treating Physician | **UPIN No.**

Requesting Physician Signature

I certify that I intend to order the services indicated which I consider medically necessary for the diagnosis and treatment of the patient. In accordance with CMS guidelines, all laboratory orders must either be signed by the ordering physician on the requisition or be documented and signed in the patient's medical record.

Duplicate Report To:

Address:

Fax:

PATIENT INFORMATION

Last Name | **MI**

First Name

Street | **City**

State | **Zip** | **Phone**

Sex: ☐ (M) ☐ (F) | **DOB**

Patient ID No. | **Chart No.**

BILLING INFORMATION

Bill to: Select One

☐ **Medicare** ☐ **Medicaid** ☐ **Patient's Insurance** ☐ **Physician Bill** ☐ **Self Pay** ☐ **Other Insurance**

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD

Patient is: ☐ **Subscriber** ☐ **Spouse** ☐ **Other Dependent**

Primary Insurance Name: | **Policy No.:**

Group No. | **Insured's Name:**

Address: | **City:** | **State:** | **Zip:**

Secondary Insurance Name: | **Policy No.:**

Group No. | **Insured's Name:**

Address: | **City:** | **State:** | **Zip:**

URINE

ICD-9 Code | Volume | ML/CC

Collection: Date | Time | ☐ AM ☐ PM | Previous Cytology Date

☐ None ☐ Negative ☐ Atypical

Specimen Type ☐ First Morning Void ☐ Bladder Wash Mal. ☐ Post Cysto Void ☐ Ileal Conduit ☐ Catherized Urine

☐ Ren Wash ☐ R ☐ L ☐ Ureteral Wash ☐ R ☐ L ☐ Random Void

Test Requested ☐ Cytology Reflex to FISH/Bladder Cancer ☐ FISH Bladder Cancer ☐ Dual Cytology & FISH Bladder Cancer

PATIENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

Patient Signature _____ **Date** _____